APPLICATION FOR HOSPITAL CARE FOR THE INDIGENT

State Form 27097 (R5 / 8-05) / FI HCI 0001

FOR OFFICE USE ONLY	
Case number	Date application received *(month, day, year)*
County of Family Resources	

INSTRUCTIONS FOR COMPLETING AND FILING THE APPLICATION

1. ***The application must be signed by the patient if he / she is medically able to sign, or by the patient's representative (legal guardian, power of attorney, or next of kin), if available****. If the patient is medically unable to sign the application and the guardian, power of attorney, or next of kin is not available, a hospital representative may sign the application.*
2. *The application must be filed with the County Office, Division of Family Resources, not more than forty-five (45) days after the patient is discharged / released from the hospital. The application can be submitted by the patient, the patient's representative, or the hospital, physician, or transportation provider.*
3. *Every question must be answered and the requested information provided.*
4. *If more space is needed, include a separate page.*

Who submitted this application? *(check one)* ☐ Patient ☐ Patient's representative ☐ Hospital ☐ Physician ☐ Transportation provider

Confidentiality Statement: The personal information requested on this form will be used in the determination of your eligibility for Hospital Care for the Indigent administered by the Division of Family Resources. Non-disclosure of the requested information could result in a denial of assistance per I.C. 12-16-5.5 and 470 IAC 11.1-1-2 *et. seq*. All personal information collected on this form will be treated as confidential pursuant to 470 IAC 1-2-7.

Name of hospital	Admission date *(month, day, year)*	Discharge date *(month, day, year)*
Address (*number and street, city, state, ZIP code*)	Telephone number	
Name of patient (*first, middle, last and maiden*)	Patient's number	Sex ☐ Female ☐ Male
Address (*number and street*)		☐ Buying ☐ Renting ☐ Other
City, state, ZIP code		County
Telephone number Home: Work:	Marital status	Social Security number
Date of birth *(month, day, year)*	Birthplace (*city, county, state*)	
Name of spouse or parent(s) *(information about parents required only for patients under age 18)*		Social Security number
Address, if different (*number and street, city, state, ZIP code*)	Telephone number Home:	Work:
Name of contact person *(check one if applicable)* ☐ Legal guardian *(court appointed)* ☐ Power of attorney	Telephone number	
Address (*number and street, city, state, ZIP code*)		

	VERIFICATION (Office use) **Source, location, and date completed**
Are you a U.S. Citizen? ☐ Yes ☐ No	
Are you a legally admitted immigrant or visitor? ☐ Yes ☐ No	
Are you a resident of Indiana? ☐ Yes ☐ No	
I was ☐ Injured ☐ Became ill — In what county?	
Nature of injury or illness	
I and/or my spouse or parent(s) receive public assistance. ☐ Yes ☐ No	
Type of assistance:	
Assistance from what county and state	

List persons you live with and their relationship to you.

Name	Relationship

VERIFICATION (*Office use*)
Source, location, and date completed

INCOME INFORMATION

I and / or my spouse or parent(s) receive money. ☐ Yes ☐ No

If Yes, the money comes from:

A. Supplemental Security income
B. Social Security
C. Veteran's Benefits
D. Railroad Retirement
E. Pension
F. Military Allotment
G. Unemployment Compensation
H. Support Payments
I. Union Benefits
J. Sick Benefits
K. Roomers and Boarders
L. Rental of property
M. Regular money from relatives
N. Other (*describe*) _____

Type (*letter*)	Name of person receiving	For whom?	Amount	How often?
			$	
			$	
			$	
			$	

EMPLOYMENT INFORMATION - PATIENT

If not employed, name of last employer

Address (*number and street, city, state, ZIP code*)

Telephone number | Left employment (*date*)

Self-employed? (*occupation*)

1. Name of current employer | Telephone number

Address (*number and street, city, state, ZIP code*)

No. of hours worked per week	Overtime hours per week	Gross pay $	How often paid?

2. Name of current employer | Telephone number

Address (*number and street, city, state, ZIP code*)

No. of hours worked per week	Overtime hours per week	Gross pay $	How often paid?

EMPLOYMENT INFORMATION - SPOUSE OR PARENT(S)

Self-employed? (*occupation*)

1. Name of current employer | Telephone number

EMPLOYMENT INFORMATION - SPOUSE OR PARENT (*continued*)

VERIFICATION (*Office use*)
Source, location, and date completed

Address of current employer (*number and street, city, state, ZIP code*)

No. of hours worked per week	Overtime hours per week	Gross pay $	How often paid?

2. Name of current employer | Telephone number

Address of current employer (*number and street, city, state, ZIP code*)

No. of hours worked per week	Overtime hours per week	Gross pay $	How often paid?

RESOURCES (*check those that apply*)

I and / or my spouse or parent(s) have resources ☐ Yes ☐ No

- ☐ A. Savings account
- ☐ B. Certificate of Deposit
- ☐ C. Checking account
- ☐ D. U.S. Savings Bonds
- ☐ E. Cash on hand
- ☐ F. Stocks or Bonds
- ☐ G. Savings and Loan Association
- ☐ H. Credit Union shares
- ☐ I. Income tax refund
- ☐ J. Other money in burial account in bank, with funeral director, or with others (*specify*) _____
- ☐ K. Other (*describe*) _____

Type	Amount	Owned by		Name of Financial Institution
		Myself	Jointly with others (*names*)	
	$			
	$			
	$			
	$			

LIFE INSURANCE

I and / or my spouse or parent(s) own life insurance. If Yes, complete below: ☐ Yes ☐ No

	1.	2.
Policy Owner		
Person Insured		
Name of Company		
Policy Number		
Beneficiary		
Face Value	$	$
Cash Value	$	$
Premiums being paid?	☐ Yes ☐ No	☐ Yes ☐ No

VEHICLE / OTHER PERSONAL PROPERTY

I and / or my spouse or parent(s) own: an (A) automobile, (B) truck, (C) recreational vehicle, (D) motorcycle, (E) motorboat , (F) camper trailer or (G) other personal property.

If Yes, complete below: ☐ Yes ☐ No

TYPE	MAKE	MODEL	YEAR	MARKET VALUE	LOAN BALANCE
				$	$
				$	$

VEHICLE / OTHER PERSONAL PROPERTY (*continued*)

TYPE	MAKE	MODEL	YEAR	MARKET VALUE	LOAN BALANCE
				$	$
				$	$

Who is the lien holder? (*name of bank, finance company, etc.*)

Address (*number and street, city, state, ZIP code*)

VERIFICATION (*Office use*)
Source, location, and date completed

REAL ESTATE

I and / or my spouse or parent(s) with whom I am living own or are buying land or buildings on / in which I (we) are not living. ☐ Yes ☐ No

If Yes, complete below:

Property address (*number and street, city, state, ZIP code*)

Estimated value	Balance owed
$	$

Who is the lien holder? (*name of bank, finance company, etc.*)

Address (*number and street, city, state, ZIP code*)

Annual taxes	Insurance	Monthly payment	Monthly income
$	$	$	$

HEALTH INSURANCE - PATIENT

I have health insurance as checked below. (*List claim numbers*) ☐ Yes ☐ No

- ☐ A. Medicare Part A
- ☐ B. Medicare Part B
- ☐ C. Workmen's Compensation
- ☐ D. CHAMPUS
- ☐ E. CHAMPVA
- ☐ F. Veteran's Administration
- ☐ G. Other benefit program (*specify*) _____

Private coverage:

☐ H. Automobile ☐ I. Patient's employer ☐ J. Spouse's or parent's employer

☐ K. Other _____

Type	Name of company

Name of insured

Coverage

☐ Hospitalization ☐ Major Medical ☐ Cancer

☐ Other _____

Type	Name of company

Name of insured

Coverage

☐ Hospitalization ☐ Major Medical ☐ Cancer

☐ Other _____

List additional health insurance below:

ADDITIONAL INFORMATION

Enter any other information about your financial circumstances or living arrangements.

READ THE FOLLOWING STATEMENTS AND INITIAL EACH BOX.

☐ The information I provided on this application is true and correct to the best of my knowledge and belief.

☐ I understand that the statements I have made on this form are subject to investigation and verification.

☐ I understand that I will be asked to provide proof of the information which I have given on this form and I agree to help the County Office, Division of Family Resources obtain the necessary verifications.

☐ I understand that a person who receives assistance by giving false information or by failing to report information may be criminally prosecuted under applicable State law.

☐ I agree to report to the County Office, Division of Family Resources any change in my family income, resources, living arrangements, or family conditions which may affect my eligibility within ten (10) days of the date on which the change occurs.

☐ I hereby authorize and direct a physician or hospital to release copies of extracted information to the County Office, Division of Family Resources from the following portions of my medical records: Identity, Diagnoses, Emergency Room Information, History and Physical, Physician's Orders, Progress Notes, Discharge Summary, Consultations, Operative Record, Diagnostic Information, Therapy, Nurses' Notes, and Itemized Bill of Charges. Unless otherwise indicated this authorization extends to such psychiatric, alcohol, or drug abuse information (*if any*) as may be contained in the records. I also authorize the County Office, Division of Family Resources to release this same information to the Indiana Family and Social Services Administration in the event of an appeal.

Signature of patient	Signature of patient's representative	Date *(month, day, year)*
Name of witness (*if above signature is by "X"*)	Address (*number and street, city, state, ZIP code*)	Date *(month, day, year)*
Signature of hospital representative if one of the above individuals is not available		Date *(month, day, year)*